20. Extended services to pregnant women.

See items 20.a. and 20.b.

20.a. Pregnancy-related and postpartum services for 60 days after the pregnancy ends.

Payment was derived from the additional costs of delivering these services above and beyond the global prenatal care package.

		Base Rate
(1)	Prenatal Risk Assessment	$5.40
(2)	At Risk Antepartum Management	$64.89
(3)	Care Coordination	$25.95
(4)	Prenatal Health Education I	$64.89
(5)	Prenatal Health Education II	$55.15
(6)	Prenatal Nutrition Education	$16.22
(7)	At Risk Follow-Up Home Visit	$52.79
(8)	Enhanced Package	$279.91

The base rates are increased by 26.5%.

20.b. Services for any other medical conditions that may complicate pregnancy.

Providers are paid in accordance with the specific services methodology set forth elsewhere in this Attachment.

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with section 1920 of the Act).

Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

Not provided.

23. Certified pediatric or family nurse practitioner services.

Certified pediatric or family nurse practitioner services are paid using the same methodology as item 6.d.E., Nurse practitioner services.

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

- See items 24.a. through 24.e.

24.b. Services of nurses in religious nonmedical health care institutions.

Not provided.

24.c. Care and services provided in religious nonmedical health care institutions.

See Attachment 4.19-D.

24.d. Nursing facility services for patients under 21 years of age.

See Attachment 4.19-D.

24.e. Emergency hospital services.

Emergency hospital services are paid using the same methodology as item 2.a., Outpatient hospital services.

25. Home and community care for functionally disabled elderly individuals.

- Not provided.

26. Personal care services.

Payment is the lower of the submitted charge, or the state agency established rate:

Procedure Code	July 1, 1997	July 1, 1998	July 1, 1999
X5643 Independent Personal Care Assistant	$1.97/unit	$2.03/unit	$2.11/unit
X5644 Supervision of Independent PCA	$4.06/unit	$4.18/unit	$4.35/unit
X5645 Personal Care by an Agency 1:1	$3.09/unit	$3.18/unit	$3.31/unit
X5657 Personal Care by an Agency 1:2	N/A	N/A	$2.49/unit
X5358 Personal Care by an Agency 1:3	N/A	N/A	$2.20/unit
X4037 Supervision of Personal Care by an Agency	$5.45/unit	$5.61/unit	$5.83/unit

[**NOTE**: 1 unit = 15 minutes]

Shared care: For two recipients sharing services, payment is one and one-half times the payment for serving one recipient. For three recipients sharing services, payment is two times the payment for serving one recipient. This paragraph applies only to situations in which all recipients were present and received shared services on the date for which the service is billed.

Fiscal agent option: Payment is the same as that paid for personal care services.

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 5 to Attachments 3.1-A/B.

- Not provided.

2.a. Outpatient hospital services.

- All services must be provided by or under the on-site supervision of a physician or dentist.

- Outpatient day treatment or partial hospital programs for mental illness must be approved by the state agency as eligible for MA payment. Prior authorization is required before initial treatment for partial hospital programs and every 30 days thereafter for outpatient day treatment and partial hospital programs.

- Nutritional counseling exceeding three visits requires prior authorization.

- Outpatient chemical dependency programs are provided for under rehabilitation services. Limitations for outpatient chemical dependency programs are provided under Item 13.d. of this attachment.

- Blood and blood components are covered to the extent these are not available from other sources. Blood charges may not exceed the cost of the quantity actually administered and not replaced.

- Outpatient hospital services includes end-stage renal disease hemodialysis. A recipient receiving hemodialysis in the home is considered to be receiving outpatient hospital services.

- Supplies and equipment ordinarily furnished by hospitals during the care and treatment of an illness or injury are not separately payable.

- Hospitals must comply with federal regulations concerning informed consent for voluntary sterilization procedures and hysterectomies.

- Second surgical opinion is a condition of reimbursement for tonsillectomy and/or adenoidectomy, hysterectomy, and cholecystostomy.

- Abortion related services are covered when the abortion is medically necessary to prevent the death of a pregnant woman, and in cases where the pregnancy is the result of rape and incest. Cases of rape and incest must be reported to legal authorities unless the treating physician documents that the woman was physically or psychologically unable to report.

2.a. Outpatient hospital services. (continued)

- Coverage of physical therapy, occupational therapy, audiology, and speech language pathology is limited to services within the limitations provided under items 11.a. to 11.c., physical therapy and related services.

- Providers who administer pediatric vaccines as noted in item 5.a., Physicians' services within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program.

5.a. Physicians' services:

- **Psychiatric services**: Coverage is limited to the following services:

Services	Limitations
Diagnostic assessment	1 assessment of up to two hours per calendar year or up to 4 assessments per calendar year, unless the recipient meets certain medical criteria established in rule; if so, MA will pay for 1 assessment of up to 8 hours.
Psychological testing	32 units per calendar year.
Neuropsychological assessment	28 units per calendar year.
Individual psychotherapy, 20 to 30 minutes	Individual psychotherapy and one half hour units of biofeedback training combined, are covered up to 26 hours per calendar year, not more frequently than once every 5 calendar days; unless additional coverage is prior authorized. *
Individual psychotherapy, 40 to 50 minutes	Individual psychotherapy and one hour units of biofeedback training combined, are covered up to 20 hours per calendar year, not more frequently than once every 10 calendar days; unless additional coverage is prior authorized.*
Individual psychotherapy discretionary	Up to 6 hours per calendar year.

5.a. Physicians' services (continued):

Services	Limitations
Family psychotherapy without patient present	Not more frequently than once every 5 calendar days, up to 20 hours per calendar year when combined with family psychotherapy; unless additional coverage is prior authorized.*
Family psychotherapy	Not more frequently than once every 5 calendar days, up to 20 hours per calendar year when combined with family psychotherapy without patient present; unless additional coverage is prior authorized.*
Family psychotherapy discretionary	Up to 6 hours per calendar year.
Multiple family group psychotherapy	Up to 10 times per calendar year, not to exceed 2 hours per occurrence.*
Group psychotherapy	Up to 78 hours per year, not to exceed 3 hours within a 5 calendar day period.*
Chemotherapy management including prescription, use, and review of medication with not more than minimal medical psychotherapy - provided the medication required is antipsychotic or antidepressant provided by a physician, clinical nurse specialist with a specialty in psychiatric nursing or mental health, or registered nurse who is also a mental health professional or practitioner and is employed or under contract with the physician or provider who is providing clinical supervision.	52 clinical units per calendar year, not more than 1 unit per week.

5.a. Physicians' services (continued):

Services	Limitations
Electroconvulsive therapy single seizure	
Multiple seizures, per day	
Explanation of findings	4 hours per calendar year.
Unlisted psychiatric service or procedure	
Biofeedback training	One-half hour units of service are subject to the same limitations as individual psychotherapy, 20 to 30 minutes. One hour units of service are subject to the same limitations as individual psychotherapy, 40 to 50 minutes.*

* In addition to these limits, unless additional coverage is prior authorized, more than 1 *type* of therapy (group, family, or individual, except for discretionary therapy) is not covered if provided more frequently than once every 5 calendar days; nor is more than a 1-hour unit of individual psychotherapy or a 1-hour unit of biofeedback training covered if provided within 10 calendar days of a ½-hour unit of individual psychotherapy (90843), or a ½-hour unit of biofeedback training.

5.a. Physicians' services (continued):

- **Sterilization procedures**: Physicians must comply with regulations concerning informed consent for voluntary sterilization procedures.

- **Laboratory services:** These services must be ordered by a physician. Only laboratory services provided by Medicare certified laboratories are eligible for MA payment. Payment to physicians is done in accordance with 42 CFR §447.10(g).

- **Abortion services**: These services are covered when the abortion is medically necessary to prevent death of a pregnant woman, and in cases where the pregnancy is the result of rape or incest. Cases of rape and incest must be reported to legal authorities unless the treating physician documents that the woman was physically or psychologically unable to report.

- **Telemedicine consultation services (until July 1, 2001):** These services must be made via two-way, interactive video or store-and-forward technology. The patient record must include a written opinion from the consulting physician providing the telemedicine consultation. Coverage is limited to three consultations per recipient per calendar week.

- **Prior Certification**: Physicians must request and obtain certification prior to admitting medical assistance recipients for inpatient hospital services, except for emergencies, delivery of a newborn, inpatient dental procedures, or inpatient hospital services for which a recipient has been approved under Medicare.

- **Delivery of services**: Physician services must be provided by or under the supervision of a medical doctor or doctor of osteopathy licensed under Minnesota Statutes, §147 and within the scope of practice defined by law. Supervised physician services are provided by enrolled physician assistants and physician extenders.

- **Second medical opinion:** Second medical opinion is a condition of reimbursement for **tonsillectomy and/or adenoidectomy, hysterectomy and cholecystostomy.**

5.a. Physicians' services (continued):

- **Organ transplants**: These services are covered in accordance with the standards and statutory authority provided in Attachment 3.1-E.

- **Physical therapy, occupational therapy, audiology and speech language pathology**: Coverage of these services is limited to services within the limitations provided under items 11.a. to 11.c., Physical therapy and related services.

- **Physician services to pregnant women**: Physicians providing these services must be certified by the Department, through a provider agreement, as qualified to provide services to pregnant women.

- **Physician services to children under 21 years of age**: Physicians providing these services must be certified by the Department, through a provider agreement, as qualified to provide services to children under 21 years of age.

- **Pediatric vaccines**: Physicians who administer certain pediatric vaccines (i.e., vaccines that are part of the Minnesota Vaccines for Children Program) within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program. The Minnesota Vaccines for Children Program is established pursuant to §1928 of the Act.

6.d. Other practitioners' services. (continued.)

E. **Nurse practitioner services** are limited to:

(1) Services performed by ~~an adult~~ a nurse practitioner~~, obstetrical/gynecological nurse practitioner, neonatal nurse practitioner, or geriatric nurse practitioner~~ certified by the appropriate certification entity and provided within the scope of practice of the nurse practitioner's license as a registered nurse; and

(2) The types of services covered by Medical Assistance as physicians' services under item 5.a. ~~and which~~ that are within the scope of the nurse practitioner's license as a registered nurse.

Nurse practitioners who administer pediatric vaccines as noted in item 5.a., Physicians' services within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program.

6.d. Other practitioners' services. (continued)

G. Coverage of **health maintenance organization services** provided consistent with 42 CFR Part 434 and state law.

6.d. Other practitioners' services. (continued)

H. **Clinical nurse specialist** services are limited to:

1) Services performed by a nurse certified by a national nurse certification organization recognized by the Minnesota Board of Nursing. This includes certification by the American Nurses Association as a clinical specialist in psychiatric or mental health under items 5.a., Physicians' services and 6.d.A, mental health services; and

2) The types of services covered by Medical Assistance as physicians' services under item 5.a. that are within the scope of the clinical nurse specialist's license as a registered nurse.

Clinical nurse specialists who administer pediatric vaccines as noted in item 5.a., Physician's services within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program.

7. Home health services.

- Covered home health services are those provided by a Medicare certified home health agency that are: (a) medically necessary health services; (b) ordered by a physician; (c) documented in a plan of care that is reviewed and revised as medically necessary by the physician at least once every 60 days; and (d) provided to the recipient at his or her own place of residence that is a place other than a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF/MR) unless skilled nurse visits have been prior authorized for less than 90 days for a resident at an ICF/MR in order to prevent and admission to a hospital or nursing facility and is not required to be provided by the facility under 42 CFR Part 483, subpart I.

- Department prior authorization is required for home health aide visits or skilled nurse visits, unless a physician has ordered such visits and:

  a) the professional nurse determines an immediate need for up to 40 home health aide visits or skilled nurse visits per calendar year and submits a request to the Department for authorization of payment within 20 working days of the initial service date, and medical assistance is the appropriate payer; or

  b) this is the first through the fifth skilled nurse visit during a calendar year.

  Department prior authorization is based on medical necessity, physician's orders, the recipient's needs, diagnosis, and condition, the plan of care, and cost-effectiveness when compared with other care options.

- The following home health services are not covered under medical assistance:

  a) home health services that are the responsibility of the foster care provider;

  b) home health services when not medically necessary;

7. Home health services. (continued)

c) services to other members of the recipient's household;

d) any home care service included in the daily rate of the community-based residential facility in which the recipient resides;

e) nursing and rehabilitation therapy services that can reasonably be obtained as outpatient services;

f) any home health agency service that is performed in a place other than the recipient's residence; and

g) more than one visit per day.

- Home health agencies that administer pediatric vaccines as noted in item 5.a., Physician's services within the scope if their licensure must enroll in the Minnesota Vaccines for Children Program.

7.a Intermittent or part-time nursing services provided by a home health agency, or by a registered nurse when no home health agency exists in the area.

- Covered intermittent or part-time nursing services are those provided by a Medicare-certified home health agency that are:

  a) medically necessary;
  b) ordered by a physician;
  c) documented in a plan of care that is reviewed and revised as medically necessary by the physician at least once every 60 days; and
  d) provided to the recipient at the recipient's own place of residence that is a place other than a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF/MR) unless skilled nurse visits have been prior authorized for less than 90 days for a resident at an ICF/MR in order to prevent an admission to a hospital or nursing facility and is not required to be provided by the facility under 42 CFR Part 483, subpart I.

- Homemaker services, social services, educational services, and services not prescribed by the physician are not paid by medical assistance.

- Home health agencies or registered nurses that administer pediatric vaccines as noted in item 5.a., Physicians' services within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program.

- Nurse visits are covered by medical assistance. The visits are provided in a recipient's residence under a plan of care or services plan that specifies a level of care which the nurse is qualified to provide. These services are:

  a) nursing services according to the written plan of care or services plan and accepted standards of medical and nursing practice in accordance with State laws governing nursing licensure;

  b) services which, due to the recipient's medical condition, may only be safely and effectively provided by a registered nurse or a licensed practical nurse;

  c) assessments performed only by a registered nurse; and

7.a Intermittent or part-time nursing services provided by a home health agency, or by a registered nurse when no home health agency exists in the area. (continued)

d) teaching and training the recipient, the recipient's family, or other caregivers.

- The following services are not covered under medical assistance as intermittent or part-time nursing services:

a) nurse visits for the sole purpose of supervision of the home health aide;

b) a nursing visit that is:

i) only for the purpose of monitoring medication compliance with an established medication program; or
ii) to administer or assist with medication administration, including injections, prefilling syringes for injections, or oral medication set-up of an adult recipient, when as determined and documented by the registered nurse, the need can be met by an available pharmacy or the recipient is physically and mentally able to self-administer or prefill a medication;

c) a visit made by a nurse solely to train other home health agency workers;

d) nursing services that can reasonably be obtained as outpatient services;

e) Medicare evaluation or administrative nursing visits for dually eligible recipients that do not qualify for Medicare visit billing;

f) skilled nurse visits (beyond the first five during a calendar year) that are not prior authorized; and

g) nursing visits when not medically necessary.

7.b. Home health aide services provided by a home health agency.

- Covered home health aide services are those provided by a Medicare-certified home health agency that are:

  (i) medically necessary;
  (ii) ordered by a physician;
  (iii) documented in a plan of care that is reviewed and revised as medically necessary by the physician at least once every 60 days; and
  (iv) provided to the recipient at the recipient's own place of residence that is a place other than a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF/MR).

- Home health aide services must be provided under the direction of a registered nurse.

- Home health aide services must be employees of a home health agency and be approved by the registered nurse to perform medically oriented tasks written in the plan of care.

- Homemaker services, social services, educational services, and services not prescribed by the physician are not paid by medical assistance.

7.c. Medical supplies, equipment and appliances suitable for use in the home.

- Covered medical supplies, equipment and appliance suitable for use in the home are those which are: (a) medically necessary; (b) ordered by a physician; (c) documented in a plan of care that is reviewed and revised as medically necessary by the physician at least once a year; and (d) provided to the recipient at the recipient's own place of residence that is a place other than a hospital, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), or licensed health care facility.

- Medical supplies and equipment ordered in writing by a physician are paid with the following limitations:

  1) A purchase of nondurable medical supplies not requiring prior authorization must not exceed an amount necessary to provide a one-month supply.

  2) Maintenance or service made at routine intervals based on hours of use or calendar days to ensure that equipment in proper working order is reimbursable.

  3) The cost of a repair to durable medical equipment that is rented or purchased by the Medical Assistance program under a warranty is not eligible for medical assistance payment is the repair is covered by the warranty.

  4) In the case of rental equipment, the sum of rental payments during the projected period of the recipient's use must not exceed the purchase price allowed by medical assistance unless the sum of the projected rental payments in excess of the purchase price receives prior authorization. All rental payments must apply to purchase of the equipment.

7.c. Medical supplies, equipment and appliances suitable for use in the home. (continued.)

- The following medical supplies and equipment are not eligible for payment:

  1) Medical supplies and equipment that are not covered under Medicare except for raised toilet seats; bathtub chairs and seats; bath lifts; prosthetic communication devices; and any item determined by prevailing community standards or customary practice to be an appropriate and effective medical necessity which meets quality and timeliness standards as the most cost effective medical supply or equipment available for the medical needs of the recipient, and represents an effective and appropriate use of medical assistance funds, is within the specified service limits of the Medical Assistance program, and is personally furnished by a provider.

  2) Routine, periodic maintenance on medical equipment owned by a long-term care facility or hospital when the cost of maintenance is billed to medical assistance on a separate claim for payment.

  3) Durable medical equipment that will serve the same purpose as equipment already in use by the recipient.

  4) Medical supplies or equipment requiring prior authorization when prior authorization is not obtained before billing.

  5) Dental hygiene supplies and equipment.

  6) Stock orthopedic shoes.

- Medical suppliers who do not participate or accept Medicare assignment must refer and document the referral of dual eligibles to Medicare providers when Medicare is the appropriate payer.

7.d. Physical therapy, Occupational therapy or Speech pathology and Audiology services provided by a home health or rehabilitation agency.

- **Covered physical therapy services** are those prescribed by a physician or nurse practitioner and provided to a patient by a qualified physical therapist. When services of support personnel are utilized, there must be direct, on-site supervision by a qualified physical therapist.

- **Covered occupational therapy services** are those prescribed by a physician or nurse practitioner and provided to a patient by a qualified occupational therapist. When services of support personnel are utilized, there must be director, on-site supervision by a qualified occupational therapist.

- **Covered speech pathology and audiology services** are those diagnostic, screening, preventive or corrective services prescribed by a physician or nurse practitioner and provided by a qualified speech pathologist or a qualified audiologist in the practice of his or her profession.

- **Restorative therapy services** are covered only when there is a medically appropriate expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time.

- **Specialized maintenance therapy** is covered only when physician orders relate necessity for specialized maintenance therapy to the patient's particular disabilities.

- **Specialized maintenance therapy** is covered only when it is necessary for maintaining the patient's current level of functioning or for preventing deterioration of the patient's condition.

8. Private duty nursing services.

- Private duty nursing services are only covered when medically necessary, ordered in writing by the physician, and documented in a written plan of care that is reviewed and revised as medically necessary by the physician at least once every 62 days.

- Except for the services identified in an Individualized Education Plan under item 13.d., private duty nursing services are not reimbursable if an enrolled home health agency is available and can adequately provide the specified level of care, or if a personal care assistant can be utilized.

- Private duty nursing services includes extended hour nursing services provided by licensed registered nurses or licensed practical nurses employed by a Medicare-certified home health agency or self-employed.

- Department prior authorization is required for all private duty nursing services. Prior authorization is based on medical necessity; physician's orders; the recipient's needs, diagnosis, and condition; an assessment of the recipient; the plan of care; and cost-effectiveness when compared to alternative care options. For recipients who meet hospital admission criteria, the Department shall not authorize more than 16 hours per day of private duty nursing service or up to 24 hours per day of private duty nursing service while a determination of eligibility is made for recipients who are applying for services under Minnesota's approved model home and community-based services waiver or during an appeal to the appropriate regulatory agency to determine if a health benefit plan is required to pay for medically necessary nursing services. For recipients who do not meet hospital admission criteria, the Department may authorize up to 9.75 hours per day of private duty nursing service.

- Authorized units of private duty nursing service may be used in the recipient's home or outside of the recipient's home if normal life activities take the recipient outside of their home and without private duty nursing service their health and safety would be jeopardized. To receive private duty nursing services at school, the recipient or his or her responsible party must provide written authorization in the recipient's care plan identifying the chosen provider